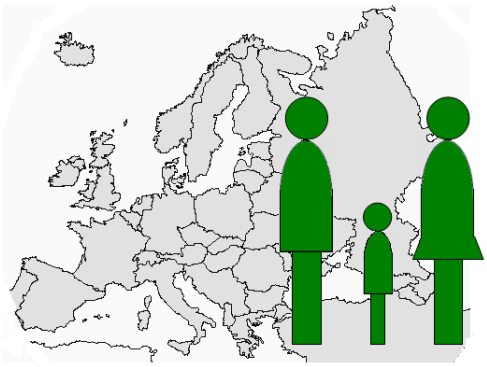
Monitoring Suicidal Behaviour in Europe



MONSUE

1st Interim Report on Implementation of the Action

1st Interim Finacial Statement

(2007-06-01 – 2008-06-01)

September 2008

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September 2008

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CONTENT

1. Aim of the project

Aim of the MONSUE project is the assessment of frequency of suicidal behaviour, its repetition as well as suicide prevention measures in Europe. Groups at risk, methods, “hot spots” and individual and social causal factors and their changes over time will be determined and proposals for the implementation of strategies to reduce this behaviour will be developed. Additionally the effect of specific preventive measures will be tested.

2. Summary of the current state of implementation

2.1 Monitoring Form

In order to ensure that the data collection was identical throughout the project, a monitoring sheet to be used by all participants was designed. For this purpose a meeting of a special group (leadership by Prof. Dr. Värnik) was held in Berlin (2005) to assess the preview. The revised monitoring form originally used in the WHO Multicentre Study on Suicidal Behaviour (Schmidtke et al. 2004) contains data concerning age, sex, place, date and time of suicide attempt, the method of the suicide attempt according to the new ICD-10 X- code and information about previous suicide attempts. Within this form information was also recorded about various sociodemographic variables, such as current marital status, household composition, religious denomination, level of education (based on appropriate national standards), level of vocational training, economic situation at the time of the suicide attempt, change of address during the past year and the treatment offered after suicide attempt (Platt et al., 1992; Schmidtke et al., 1993, Schmidtke et al. 2004).

Previous forms were modified and improved; the current form is attached in appendix 2. In the current form, used by the centres since 2008, new variables have been included with regard to the ethnical background of the families of suicide attempters like “duration of living in the country of current residence, “country of destination”, “Ethnicity”, “mothers` country of birth” and “fathers` country of birth” (UN-Code for countries). Another topic also concerns the family of origin with regard to being

brought up in a traditional family, by a single parent, by other relatives, in adoption or care families or in institutions. Another special interest is the work situation of suicide attempters. New variables were created with regard to occupation (according ISCO88) and level of economic position. Also more detailed information on the method of the suicide attempted is collected: it needs to be recorded whether the medication used for the suicide attempt is prescribed or not. Also the place of the suicide attempt should be recorded. Furthermore the treatment after previous suicide attempts including health system and other services and reasons for the suicide attempt (interpersonal conflict, bereavement or severe illness of family member/partner/friend, physical illness, mental health disturbance, financial difficulties, mistreatment and legal problems) are gathered. For the use of the monitoring form and the coding a “cookbook” was designed, which is under continuous examination and revision.

2.2 Meetings

In February 2005 the first general meeting of the project participants was held in Würzburg to prepare the study, despite the fact that the financial contribution from EU was not yet available at this time. It was decided, that the WHO-monitoring form had to be complemented. Afterwards the Monitoring form to assess suicide attempts was modified by the task group in April 2005. A meeting in Berlin was held for this reason and the new variables were included.

2.3 Development

After long negotiations with some centres, which finally withdrew their participation due to financial reasons, the project started officially in June 2006 with 17 centres. Old and new centre leaders were continuously informed about the status quo of the project.

In autumn 2006 all centres were informed about the start of the project and received by post and e-mail the necessary information to start the project. A timetable, with the

specified tasks at this stage was distributed, as well as the new monitoring form and the coding lists.

The first task for most centres was to define the catchment area, in which the suicide attempts should be collected.

The second task was the translation of the monitoring form in the individual languages.

The third task was to collect the suicide data for the country and the catchment area and important intervention projects in the field of suicide prevention should have been listed.

Up to now, no second general meeting has been held, because of the late money transfer from EU. Unfortunately most of the centres were not able to invest further prefinancing. The coordination centre received the first tranche of money in March 2008 and the next meeting could be planned.

2.4 Available data and results

2.4.1 Suicides

In general in a first step suicide data were collected with the help of EUROSTAT and the WHO-database. In addition newer data are collected with the help of the individual centres and country representatives from IASP.

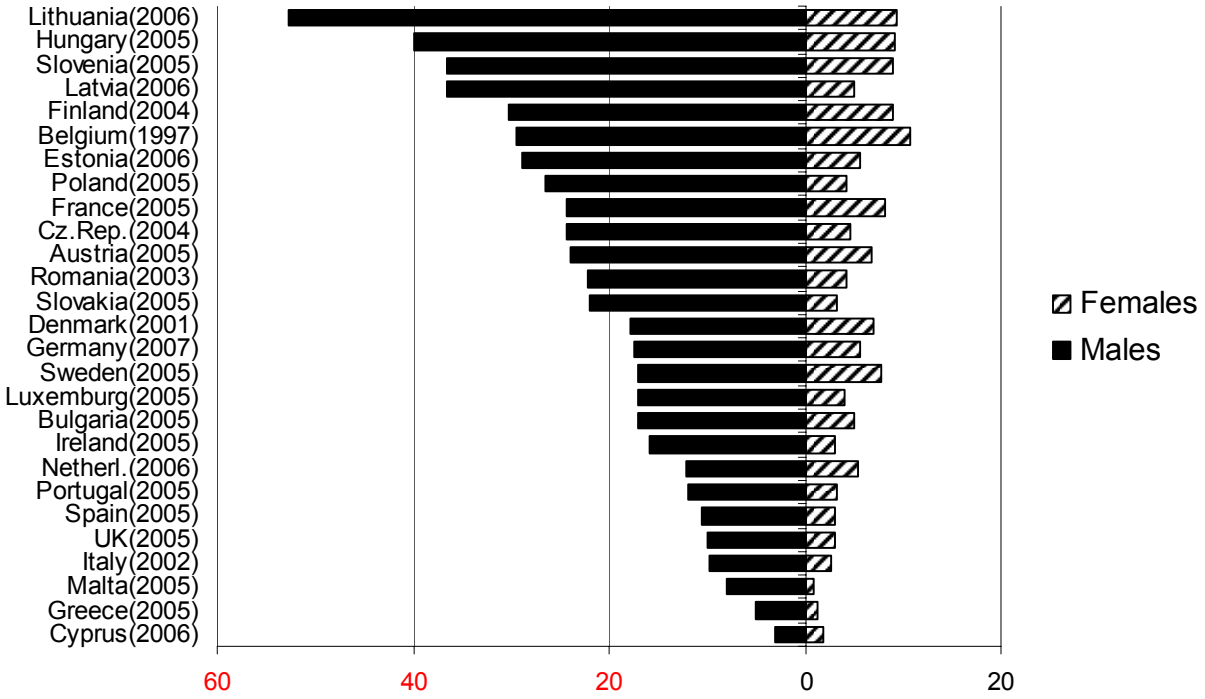

Figure 1: Suicide rates in Europe (EUROSTAT Database, last available year)

The data were ordered in 5-year age groups according to the male and female rank order of the suicide figures of the individual countries. Data from EUROSTAT are more current, but only split into gender and not into different age-groups. Data from the WHO-database are rather old (about 5 years), but split into 10-years age groups and into gender. Accordingly for current analyses, which also include suicide methods, we are dependent on detailed information from the associated beneficiaries. Up to now actual suicide data have been sent from Estonia (2004 to 2006), Hungary (2007 to 2008/1) and Italy (2004, data from Italy are not spilt into 5-years age groups).

Based on the data of Värnik et al (2008) also the main suicide methods in the individual countries were determined. Missing data were requested from the centres and the IASP representatives.

To check the validity of the suicide data also the rates of the undetermined death were analysed and rank correlations computed.

2.4.2 Suicide attempts

The following table includes a summary of available data, which were collected with the WHO-monitoring form. Centres were split into those, which gain financial contribution from the EU and those, which participate in the WHO network without financial assistance.

Associated beneficiaries	Time period covered	Centers without EU-funding	Time period covered
Würzburg	1989-2006	Bern	1989-1990, 1993-1998
Hall	./.	Bordeaux	1989
Salzburg	./.	Dobrich	2006
Brussels	./.	Emilia-Romagna	1989-1994
Odense	1989-2000	Gent	1996-1999
Tallinn	1995-2000	Guipuzcoa	1989-1991
Helsinki	1989-1997	Holon-Bat-Yam	1990-2006
Nancy	./.	Innsbruck	1989-1998
Leipzig	./.	Leiden	1989-1992
Hamburg	./.	Ljubljana	1995-2002
Pecs	1997-2001	Odessa	1998-2003
Campobasso	./.	Oxford	1989-1999
Riga	./.	Padova	1989-1996
Koper	./.	Rennes	1995-1996
Oviedo	2003	Sor-Trondelag	1989-2000
Stockholm	1989-2005	Szeged	1989-1991
Ankara	1998-2000	Umea	1989-1995

Table 1: Summary of available suicide attempt data

Table 2 contains information on the number of episodes and persons gathered in each centre so far. On the whole since 1989 more than 60.000 episodes conducted by more than 44.000 persons have been recorded by the monitoring form in 25 centres.

Centre	Episodes	Persons
Würzburg	2625	2257
Odense	9022	5410
Tallinn	3454	3095
Helsinki	4097	3100
Stockholm	6248	4029
Pecs	1295	1035
Oviedo	215	175
Ankara	312	302
Bern	1714	1432
Bordeaux	1215	1123
Dobrich	84	81
Emilia-Romagna	954	791
Gent	1816	1415
Guipuzcoa	230	189
Holon-Bat-Yam	2969	2832
Innsbruck	2947	2105
Leiden	793	627
Ljubljana	1673	1301
Odessa	2332	2264
Oxford	5848	3323
Padova	1128	911
Rennes	2351	1975
Sor-Trondelag	3796	2610
Szeged	1167	982
Umea	1980	1194
	60265	**44558**

Table 2: Number of persons and episodes gathered in each centre up to now

Beside the collection of the suicide attempts with the monitoring form, tables have been sent to each centre, to fill out suicide attempt methods and suicide attempt

rates separately for the last available year. Up to now we received the mentioned tables form Estonia (2004 to 2006), Hungary (2007 to 2008/1) and Italy (2004).

For the following results person-based data gathered so far in the Centres following were used: Odense, Helsinki, Würzburg, Stockholm, Tallinn, Pecs, Oviedo and Ankara.

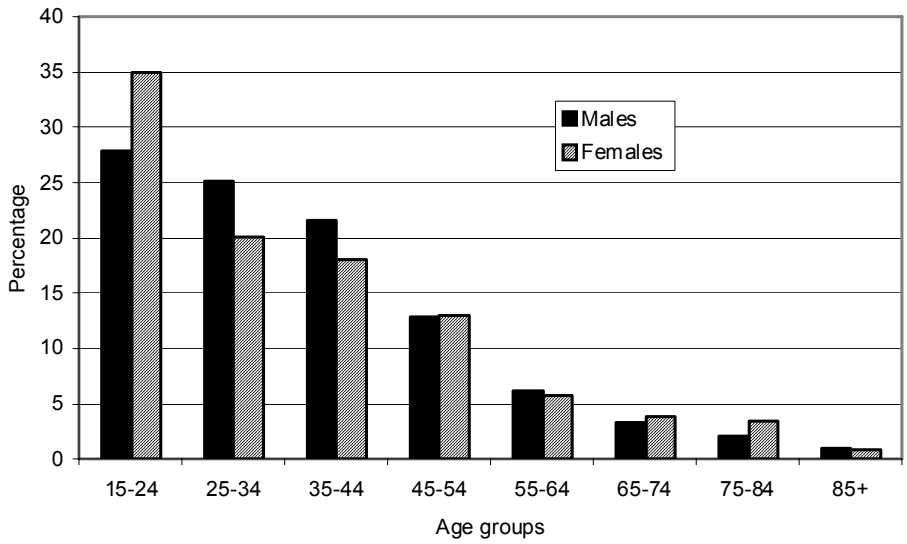

Figure 2: Age distribution

Figure 2 shows the average proportion of each age group of male and female suicide attempters.

The highest person-based percentage for male suicide attempters was found among the 15-24-year-olds with 28%. All other age groups of male suicide attempters had markedly lower percentages. For female suicide attempters the highest percentage was also found for the age group 15-24 years, average person-based percentage here was even 35%. The percentages in the age groups decrease with age for male and female suicide attempters: the older the age groups, the lower the percentages.

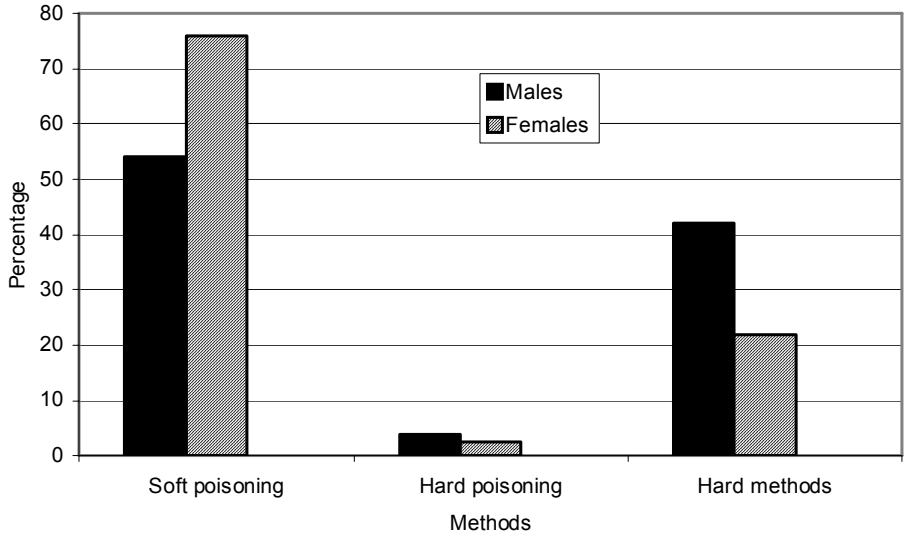

Figure 3: Methods used for the suicide attempts

Figure 3 shows the average percentages of the various methods of attempted suicides. Generally, the methods used for the suicide attempt were mostly "soft": 54% of the males and 76% of the females used these methods. “Hard methods” (e.g. “cutting”, “shooting”, "jumping or lying before moving object", “car accident”) were the next frequently used method, mainly done by males 42%, but also by females 22%.

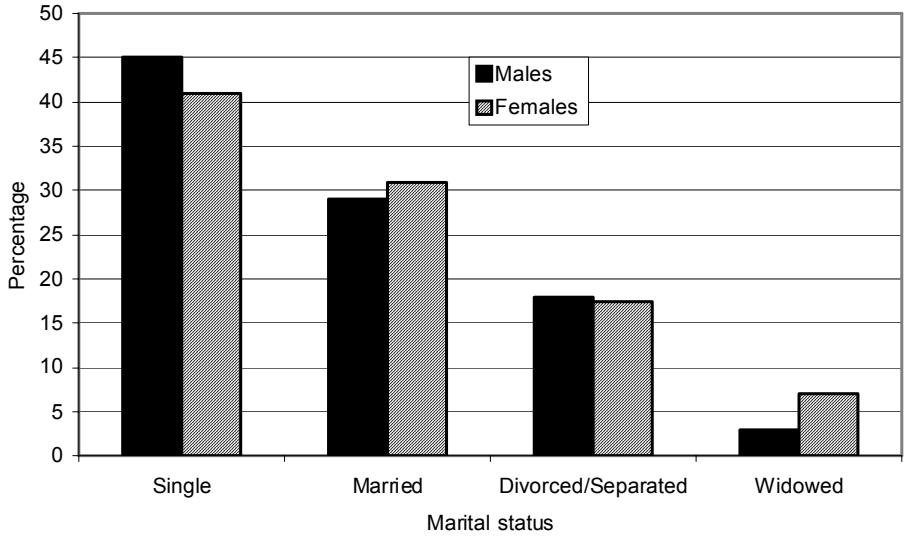

Figure 4: Marital status

The analysis according to marital status showed that the category with the highest average percentage was that of single persons (Figure 3): 45% of the male and 41% of the female suicide attempters were never married. About 1/3 of all suicide attempters were married (males: 29%; females: 31%). 18% of the male and female suicide attempter were divorced or separated.

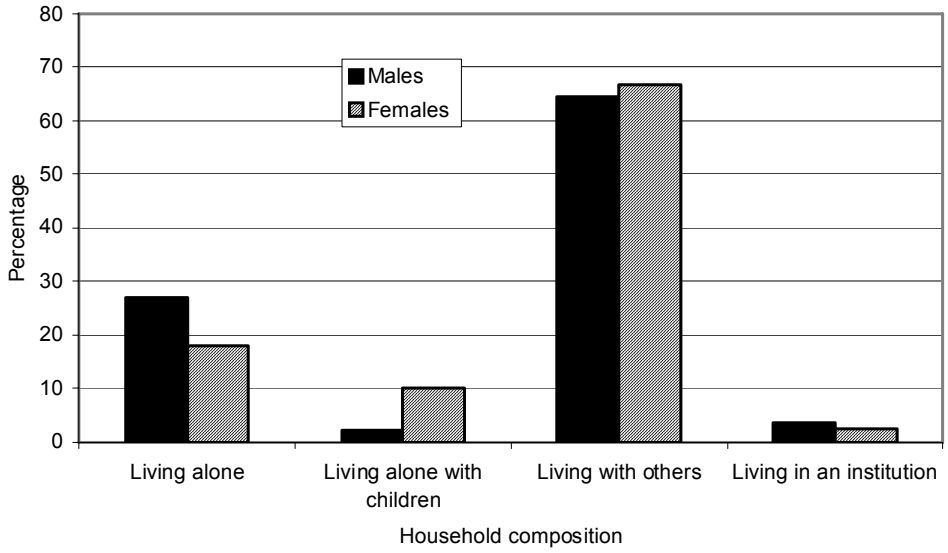

Figure 5: Household composition

An average of 27% of the male and 18% of the female suicide attempters were usually living alone (Figure 4). 2.2% of the males and 10% of the females were living alone with child(ren). 65% of the males and 67% of the females were living with others, e. g. parents, partner, other relatives and friends. 4% of the males and 3% of the females were living in an institution (clinic, sheltered home etc.).

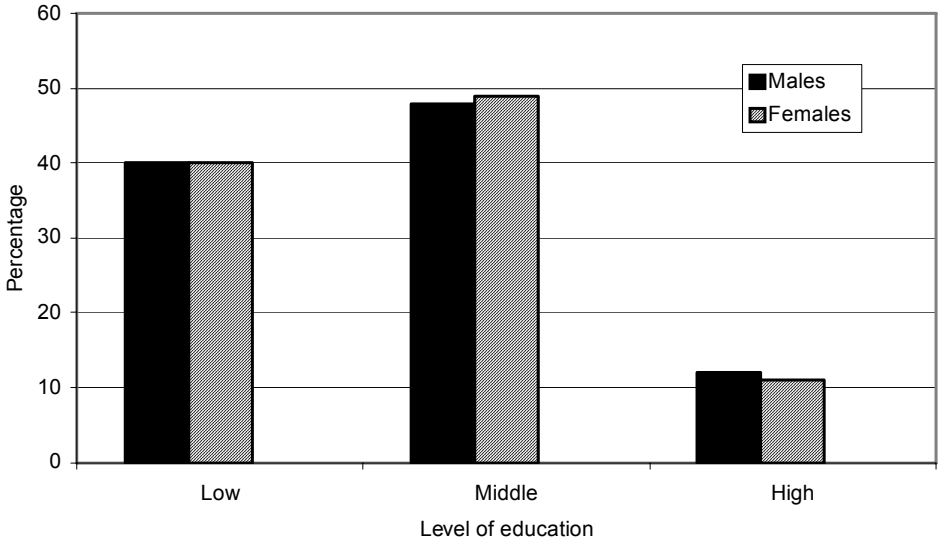

Figure 6: Formal education

For international comparisons, the various national educational categories were splitted into three categories: low, middle and high levels of education. During the first period, an average of 40% of both male and female suicide attempters had only had a low level of formal education (Figure 5). Only 12% of the males and 11% of the females had a formal education at the highest level.

The picture was similar with regard to vocational training. A high average percentage of both male (32%) and female (39%) suicide attempters had received no vocational training (see Figure 6).

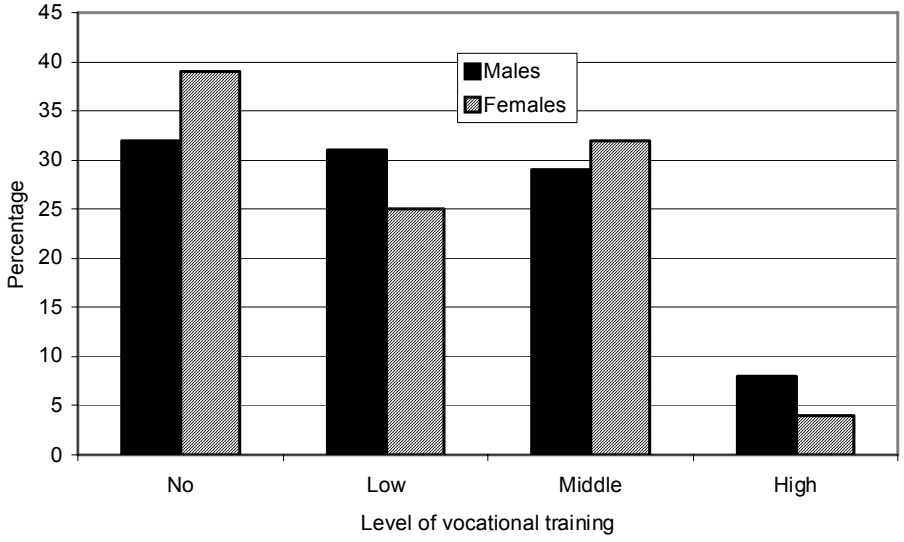

Figure 7: Level of vocational training

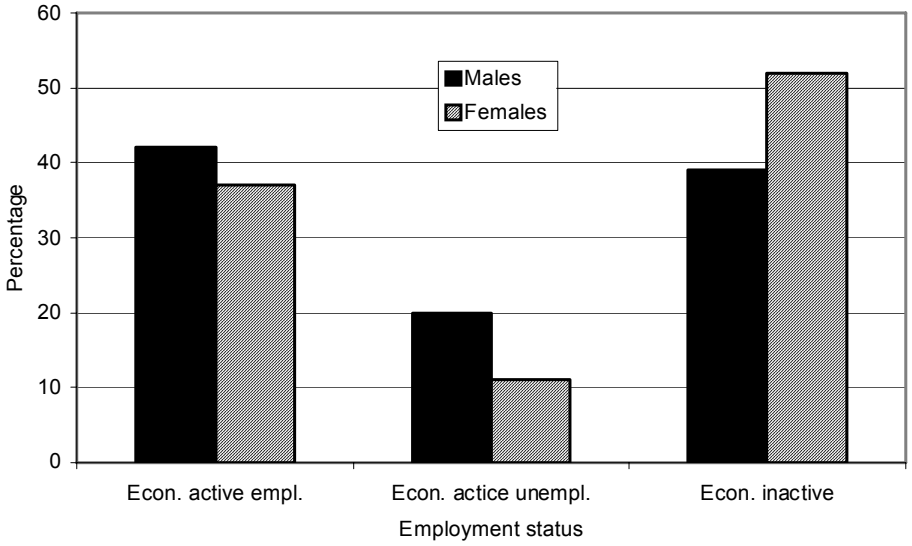

Figure 8: Employment status

Of the suicide attempters who were economically active (those who were able to work) many were unemployed: An average of 20% of all male and 11% of all female suicide attempters in the various catchment areas were unemployed. 39% of the males and 52% of the females were economically inactive (see Figure 7). These figures show that almost two thirds of all suicide attempters were not working.

Psychiatric diagnoses were collected in five centres (Emilia, Padova, Wuerzburg, Innsbruck, and Sor-Trondelag). The diagnoses were made by psychiatrist. Since at the beginning of the study ICD-9 was used, the diagnoses were made according to chapter V of this classification system. Figure 9 shows the results. In the five centres, approximately 33% of the attempters were diagnosed as suffering from a psychiatric disease. Würzburg was the centre with largest percentage of people among whom a diagnosis was made (71% of all attempters); In the second period, in Pecs the proportion was 100%.

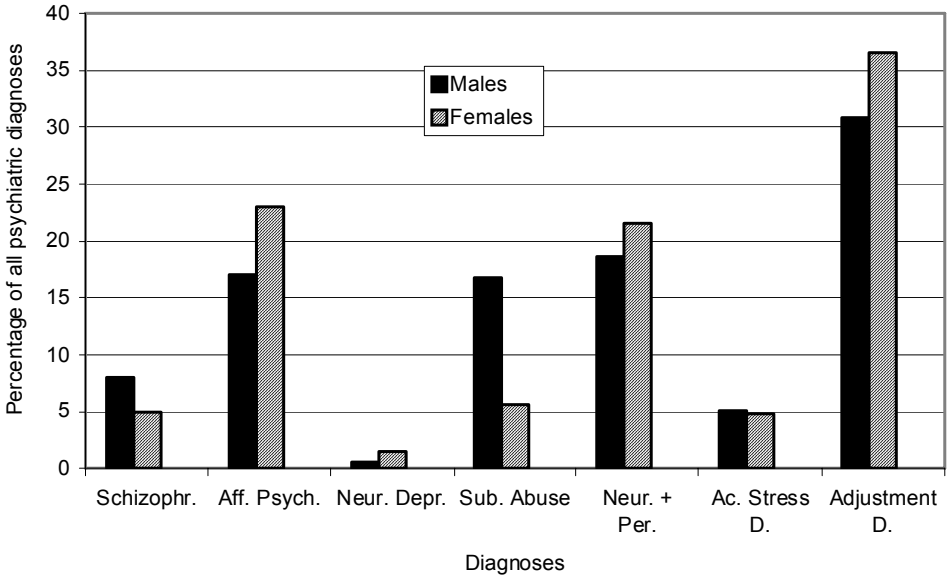

Figure 9: Diagnoses

The most prevalent diagnosis for males was adjustment disorder (31%). The second most numerous category was personality disorders (19%), followed by addiction (substance and alcohol) and alcohol and substance (17%) and affective disorders (17%). For females most frequent diagnosis was also adjustment disorder (37%), followed by affective disorders (23%) and personality disorders (22%).

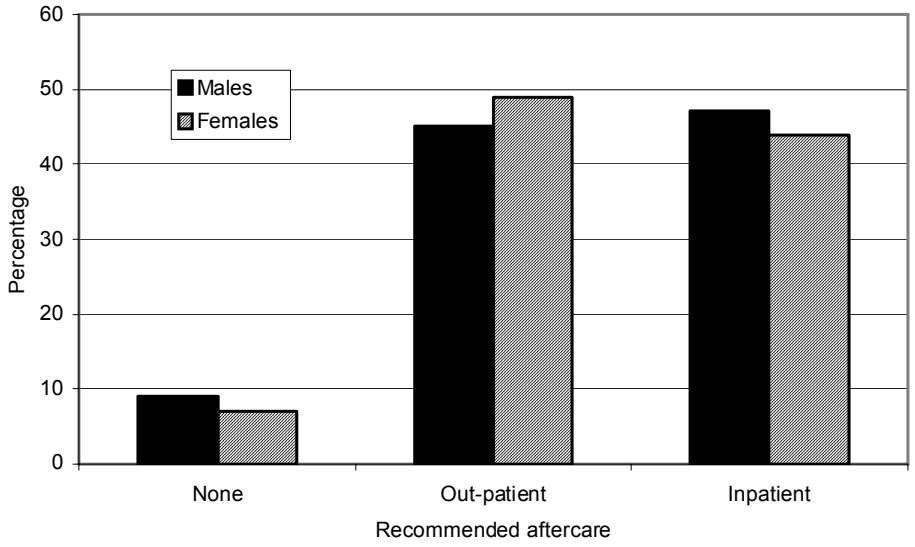

Figure 10: Recommended aftercare

For an average of 9% of all male and 7% of all female suicide attempters no further treatment was recommended after the acute medical treatment. For almost the same amount of male and female suicide attempters out- and inpatient aftercare (Males: 45%/47%; Females: 49%/44%) was recommended.

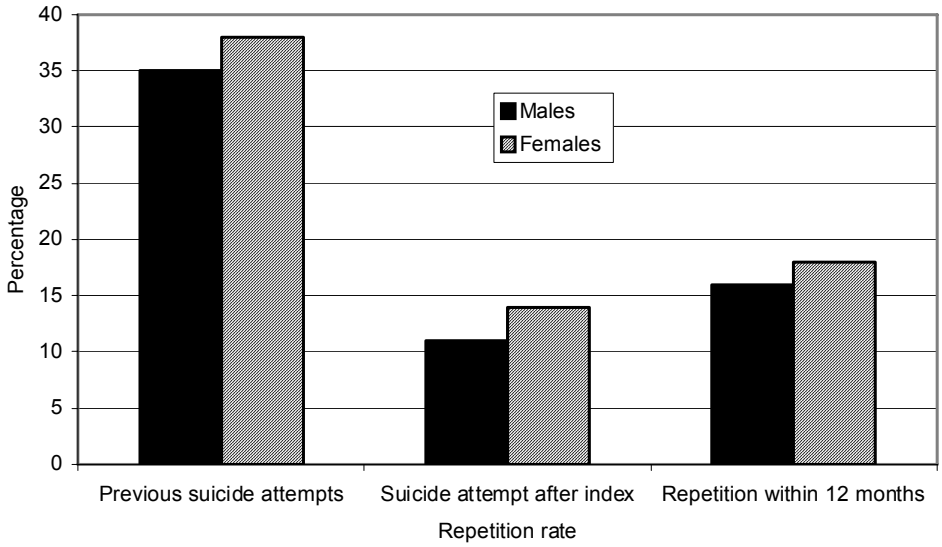

Figure 11: Repetition rates

Already in the first observation period a high percentage of previous suicide attempts were found in both males (35%) and females (38%). Of the index suicide attempters, an average of 11% of the males and 14% of the females made one or more further suicide attempts after they were included in the study. 16 % of the males and 18% of the females repeated the attempt within 12 months.

3. Activity reports of the individual centres

3.1 The Coordination Centre in GERMANY: Würzburg (University of Würzburg, Clinic for Psychiatry)

Suicide data for Germany are available from 1952 to 2007, suicide data for the catchment area Würzburg from 1989 to 2006. Suicide attempt data, collected with the official monitoring form have been collected since 1989. Up to now they have been analyzed till the year 2006. Suicide attempt data for 2007 and 2008(1) have already been collected, but still have to be integrated in the database.

The Würzburg centre took over special analyses of the suicide attempt method “car accident”. The aim of this special analysis should be to develop a profile for suicide attempters with this method (e.g. age, sex, time, previous suicide attempts, psychiatric diagnoses, and other motives). The results should allow a better identification or develop hypotheses for single car accidents as suicides or suicide attempts.

Würzburg is also developing special analyses to identify hot spots of suicides and suicide attempts. The aim of these analyses is to develop criteria to prevent developing hot-spots (e.g. bridges, hospitals, train lines etc.) or to secure and develop prevention measures for hot-spots. First analyses on European and some country levels have already been performed.

3.2 The associated beneficiairy in AUSTRIA: Hall (Psychiatric Hospital)

Up to now, no information about the status quo of the data collection has been received form the Austrian centre (Dr. Haring). The request for the first interim report remained unanswered. Furthermore the bank information, which was sent to the coordination centre, was incomplete, so that the money could not be transferred. Despite a lot of e-mails and letters the missing information was not sent.

3.3 The associated beneficiary in AUSTRIA: Salzburg (Suicide Prevention)

Also the second Austrian centre (Dr. Fartacek) has not reacted yet to the contact attempts to gain the bank information, and did not answer our requests about the status quo in his centre. Due to this, up to now no conclusions for this centre could be made. Recently we received the information that Dr. Fartacek is severely ill.

3.4 The associated beneficiary in BELGIUM: Brussels (Centre Hospitalier Universitaire Brugman)

The first EU-prefinancing was transferred to the centre in July 2008. Unfortunately so far we received no interim report from Belgium (Prof. Pelc).

3.5 The associated beneficiairy in DENMARK: Odense (Centre for Suicide Research)

The first EU-prefinancing was transferred to the centre in May 2008. Suicide attempt data collected with the WHO-monitoring form are available from 1989 to 2000.

The districts of Funen consits of Assens, faaborg-Midtfyn, Kerteminde, Langeland, Middelfart, Nordfyns, Nyborg, Odense, Svendborg, Aeroe. Inhabitants on July 1, 2008 are 483, 123.

Three institutions are involved in the Monitoring process: Odense University Hospital, Svendborg Hospital, Middelfart Hospital.

The procedure of data collection in Odense is the following: from lists of patients who habe been in contact with the abovementioned hospitals due to attempted suicide or self-harm, case records for closer examination are selected to determine if they meet WHO’s definition of a suicide attempt. Records, which meet the requirements, are

registered along with background information in the monitoring form. Employees of the Centre for suicide Research make the registration.

No new monitoring forms have been completed up to now. The calculation factor is estimated at 1. No data files have been sent to the coordination centre up to now.

Raw data is an extract of the Danish Causes of Death Registry. The years 1990-2001 are already available , the years 2002-2006 will be available soon.

Unknown cause of death (method of death where it is uncertain whether the cause of death is suicide, accident, or crime) can be split up in gender, age, method (according to the ICD-10 classification). Data source is the Danish Causes of Death Registry. Years available are from 1990 to 2001, the years 2002-2006 will be available soon.

Regarding the ‘group at risk’, data from the Registers for suicide/Suicide Attempts are analyzed constantly according to gender and age. For a more detailed analysis of risk groups, the Registers for Suicide/Suicide Attempts are linked with other registers at an individual level. ‘Dangerous methods’ and ‘hot spots’ are not analyzed.

As information source articles are used for analyses.Indicators for ‘group at risk’, ‘dangerous methods’ and ‘hot spots’ have not yet been developed.

Suicide data are available from 1970 to 2001 splitted into date, age, gender, method and counties. Suicide attempts are available from 1990 to 2004 splitted into date, age, gender, method, municipalities and socioeconomical variables. Up to now no data files have been sent to the coordination centre.

The level of preventive interventions (e. g. country, county, catchment area, schools, university, organisations) is the Catchment area.Responsible organisation of preventive interventions is the Odense University Hospital. A comprehensive suicide prevention plan in Denmark does neither exist for the country, nor for the catchment area.

3.6 The associated beneficiary in ESTONIA: Tallinn (Estonian-Swedish Suicidology Institute)

Suicide attempt data collected with the WHO-monitoring form are available from 1995 to 2000.

The catchments area of the Estonian centre comprises of the city of Tallinn, which is the capital and the largest city of Estonia. It is located in the north of Estonia and according to the Statistical Office (2007) it has 396,852 inhabitants, of whom 54.9% are women and 45.1% are men. For the same year, data indicate that in whole Estonia there were 1,342.409 inhabitants. In 2007, 54.9 % of the Tallinn residents were Estonians, 36.5% were Russians, 3.6% were Ukrainians, and in smaller percentages there were also present other ethnicities (Belarusians, Finns, etc.). In Tallinn the proportion of employed persons aged 16 until pension age was 92.6% (2007). The employment rate (age group 16 until pension age) in the same year was 77.4% and unemployment rate was 3.4% (2007). The share of pensioners in total population of Tallinn was 26% (2007). The religion for Estonians is mainly Protestant, but the Russian minority belong to the Russian Orthodox Church. The catchment area is well-developed urban district, so it shouldn't be taken as representative of a whole country.

Tallinn has eight hospitals, of which one participated in the data collection. It was the North Estonian Regional Hospital (the Tallinn Mustamäe Hospital and the Tallinn Psychiatric Clinic). This general hospital admits mainly patients aged above 15 years. However, the data from Tallinn children`s hospital that admits child patients till age of 15 were not available at the time of composing this Interim Report.

Data was gathered through collection of the standardised forms filled in at hospitals by the Emergency Ambulance Service and through case records sorted by medical staff. Team members were regularly checking the hospitals daily record of all receptions. At the end of each month the list was controlled by scanning the hospital patient-register for admissions where the diagnosis might cover a suicide attempt. Medical records were then used to identify possible cases of suicide attempts.
The number of monitored cases for the period 2004-2006 was 1013.

The estimation factor couldn´t be calculated to the time of compilation of this Report. The data for estimating it is still under collection as some data for three (3) age groups (0-15 years), should arrive from Tallinn Children`s hospital.

The raw data and suicide rates for the country were available through the World Health Organisation – European Detailed Mortality Database (DMDB). Data were split up in gender and age groups as 5 years periods starting 0-5 years group till 85+ year group. The number of cases was shown according to year and using ICD-10 codes. The last available year for the country data through WHO-DMDB was 2005, so Estonian Statistical Office has sent the country data (raw data for suicides) for the year 2006. The data for catchment area (Tallinn) was sent by Estonian Statistical Office for the years 2004-2006. The data was split up according to gender and age in 5-years age group starting with 0-5 year group and ending with age group 85+ years. To make a short description as the data sources Estonian Statistical Office and WHO-DMDB were used and data were available for the years 2004 until 2006. Regarding correlating causes of death: undefined causes of death (Y10-Y34) and car accidents (V43-V49), the data are available through World Health Organisation – European Detailed Mortality Database (DMDB). The data for number of deaths, crude death rate per 100,000 and percentage of all deaths classified in mentioned ICD-10 codes are available. Previously mentioned data can be split up in gender and 5 year age groups, starting with group 0 year of age till group 85+ years of age. The last available year for the data trough WHO - DMDB is 2005.

Tallinn is performing special analyses with regard to European suicide and suicide attempt methods with regard to age and gender. The aim of these special analyses will be to determine the main suicide and suicide attempt methods in the various participating countries for the purpose to develop special prevention programmes.

The first rate for Tallinn was transferred in April 2004. Prof. Värnik contacted the coordination centre to clarify, whether costs, which occurred before the modified project duration could be announced in the report. Aditionally there has been a change in leadership: MD Zrinka Laido will replace Prof. Värnik.

3.7 The associated beneficiary in FINLAND: Helsinki (National Public Health Institute Helsinki FINLAND)

For Finland suicide attempt data are available from 1989 to 1997.

The EU-prefinancing was transferred to Finland (Prof. Lönnqvist) in April 2008. The financial sheet for the first reporting period was sent to Würzburg in August 2008. The interim report as regards content will be sent in due time.

3.8 The associated beneficiary in FRANCE: Nancy (University of Nancy, Hopital Jeanne d´Arc)

The centre in France (Prof. Kahn) informed the coordination centre, that data collection modalities still have to be clarified. The translation of the monitoring form is in progress based on material requested by the coordination centre (Würzburg) from Rennes, Bordeaux, Pontoise and Odense. The interim report was not sent to the coordination centre in time.

3.9 The associated beneficiary in GERMANY: Leipzig (University of Leipzig, Clinic for Psychiatry)

For Germany as well as for the catchment area Leipzig suicide data for the last years including 1980 till 2007 are available. These data are split up in gender, age groups (5 years) and methods of suicide according to ICD-10 (X 60 – X 84). Data are available from the Federal Statistical Office Saxony for the years 1980 to 2007. Data for the year 2008 will be available in July 2009. No data files have yet been sent to the coordination centre. Leipzig requested the data for all available years. The data file will be send for the year 2007 as soon as the centre gets it from the Federal Statistical Office.

In the catchment area Leipzig (506,578 inhabitants) four hospitals and 20 practice-based psychiatrists are involved in the MONSUE – project. Out of six hospitals in the catchment Leipzig all three hospitals with a department of psychiatry were chosen for participation in the MONSUE – project. Furthermore the Klinikum St. Georg was chosen because of its large catchment area and the important accident and emergency unit. The four participating hospitals are:

1. Universitätsklinikum Leipzig
2. Parkkrankenhaus
3. Sächsisches Klinikum Altscherbitz
4. Klinikum St. Georg

Moreover all psychiatrists who reported having patients with suicidal behaviour were included, i.e. 20 of 40 practice-based psychiatrists in Leipzig.

The treating physician or psychologist fills out the monitoring form in the hospitals or practices. To avoid mistakes all physicians and psychologists were instructed by the project coordinator how to fill out the monitoring form. The project coordinator is responsible for coding the questionnaires in the hospitals/practices. The pseudonyms allow the identification of repeated suicide attempts, but do not disclose the identity of the person. In regular meetings the current results are presented to physicians and psychologists.

Approximately 170 monitoring forms have been completed (since October 2007). Most questionnaires were completed in hospitals with a department of psychiatry. Only five monitoring forms were filled out in practices. No data files were sent to the coordination centre, yet.

3.10 The associated beneficiary in GERMANY: Hamburg (University Hospital)

Suicide attempt data have not yet been analysed.

After long negotiations with the centre in Hamburg, a new catchment area will be defined. Due to changes in responsibilities in the institution (TZS) and the financial

situation, the project was finally be accepted in August 2008. Accordingly the money was able to be transferred in August 2008 and no report is available at this stage.

3.11 The associated beneficiary in HUNGARY: Pecs (University Medical School of Pecs)

Suicide and suicide attempt data (numbers, rates, methods) split into gender and five-years have been sent to the coordination centre for 2007/2 and 2008/1. The data, which were collected with the monitoring form have not yet been sent.

Hungary is a country with a high suicide mortality, but with decreasing suicide rates (45/100 000 in 1985 but 33/100 000 in 1998 and 25/100 000 in 2006 and in 2007). Since parasuicides had not been systematically recorded in Hungary previously, a monitoring project within the framework of the WHO/Euro Multicentre Study on Parasuicide was started in Pécs catchment area in 1997. Pécs (Hungary) centre has participated for five years in this study. The mean annual rates of medically treated suicide attempts (events) were in Pécs (1998) 196/100,000 for males and 321/100,000 for females. The MONSUE project started in 2007 jun.01. The Pecs centre catchment area covers the whole area of Pécs, i.e. the city, the suburban areas as well as the surrounding municipalities with a total population of 290 000 inhabitants. It includes mainly an urban but also a rural population and there is no difference in the distribution of the population into the main economic sectors compared to Hungary as a whole. Sex and age distribution are similar, it therefore appears that Pécs and its surroundings can be considered representative for Hungary regarding the main sociodemographic variables. The region is predominantly Catholic. The vast majority of the people attempting suicide in Pécs are brought to the general or university hospitals, admitted and treated on emergency or intensive care units. They are regularly seen by a consultant psychiatrist. Generally, inpatient or outpatient psychiatric or psychotherapeutic treatment is recommended. About one third of the suicidal patients are treated temporarily in the crisis ward of the university hospital. Unfortunately, there is a high drop-out rate in the outpatient treatment because of the integration of aftercare system is not appropriate.

The information on attempted suicide in the Pécs area reported here has been based on referrals to the main general hospital. It does not include information on attempts which were not referred to the hospital. In Hungary, suicide attempters or their relatives call an ambulance via emergency number and no general practitioner has to be involved. The number of referrals to the consultation service of our psychiatric clinic has not changed considerably, indicating a relatíve stability of the numbers of medically treated suicide attempters. Information on demographic characteristics of suicide attempters was registered through a monitoring system. Relatively full information is collected for patients referred to and assessed by the general hospital psychiatric service. On the basis of information from the emergency services, out-and inpatient facilities, it was estimated that the percentage of reported suicide attempts in the one year period amounted to 80% of all medically treated suicide attempts in the catchment area. Data on the general population in the catchment area were derived from national, régional, and municipal bureaux of statistics. Generally, reporting was reliable and it was believed that the extrapolation of the recorded data with a factor of 1.3 is realistic. It is known from previous experience that the number of cases dealt with solely by general practitioners in the Pecs area and not referred to hospital is probably quite small. No idea of the number of episodes which occur in the community is existent. The Pecs centre is confident that the method of registration of cases referred to the general hospital is as complete as possible.

The information on completed suicide in Pecs centre area has been based on data from the Dept. of Forensic Medicine, Pecs University. All of the autopsies in the area have been performed by this institute. Data on the general population in the catchment area were derived from national, régional, and municipal bureaux of statistics. No systematic suicide preventive plan/program has been performed in Pecs area, except the usual health care/psychiatric inpatient and outpatient activity of our uni-clinic /for the adults and for the adolescent/ and a hotline/crisis outpatient service.

Up to now suicide data collected with the monitoring form are available for the year 1997 to the year 2001.

3.12 The associated beneficiary in ITALY, Campobasso (Università degli Studi del Molise)

Raw data on suicide and suicide rates for our country and our catchment area have been collected from ISTAT national Institute, which only in Italy has reliable statistic demographic data. Data available are split by three broad bands of ages (0-18, 19-64, 65 and over) and by gender. Data on methods are available by gender but not by age. Last year available is 2004. Tables with the above-mentioned data have been sent to the coordination centre.

The Molise Region in Italy has 320.074 inhabitants. Monitoring activity is implemented in the General Hospitals of Molise that have an Emergency Department (1) Campobasso, 2) Isernia 3) Termoli 4) Venafro), plus a Hospital Structure for Research and Treatment located in Molise, Venafro (Neuromed). In fact, suicide attempters after their act are commonly referred, either by health personnel, or by family, or by law officers, to the nearest Emergency Department, regardless of degree of lethality of act. For the same reason, suicide attempters in Italy usually do not refer to General Practitioners, who rather may collect patients' reports either of suicidal ideation, or previous suicide attempt/s. However, these data (patients' reports) are neither reliable, nor could resemble matter of study for the monitoring project. The monitoring form is filled in by the Emergency Department Physician who admits the suicide attempter and fills in the medical notes. 22 monitoring forms for the period June 2007- June 2008 have been collected. The monitoring activity is performed on an actual basis, no calculation factor has been provided. A data file with the monitoring activity on suicide attempts for the period June 2007- June 2008 has been sent to the coordination centre.

Assessment of correlating causes of death has not been carried on so far since the very recent institution of the Molise Catchment Area, as organizing resources have been utilized centering on the basic data collection and collection chain mechanisms reliability testing. Data will be available by 2009.

Money transfer of the first EU-tranche was done in May 2008. The interim report was sent on time, but the financial report is still missing.

3.13 The associated beneficiary in LATVIA, Riga (Mental Health Government Agency)

Number and rates for suicides in Latvia were sent for 1970 to 2006, split into gender. Additionally suicide attempt data for Riga breakdown by gender and five-years-age-groups for the years 2002-2006 and repeated suicide attempts breakdown by age groups for 2001-2006 have been sent to Würzburg. Furthermore suicide attempt methods for 2002-2006 are available. All information was listed in the Statistical Yearbook of Mental Health Care in Latvia (2006). Unfortunately suicide attempt data have not been collected by using the official monitoring form.

A new department has overtaken suicide prevention activities (Public Health Agency, Mr. Likops). Due to this a new leader has to be determined. Accordingly the financial information and the interim report were not sent to Würzburg in time. The first EU-prefinancing could not be transferred.

3.14 The associated beneficiary in SLOVENIA: Koper (University of Primorska)

In Slovenia the situation was unfortunately complicated since Dr. Marusic passed away. Dr. Brodnik took over the leadingship after Prof. Marusic death.

The catchment area in Slovenia is the Podravska region, encompassing approx. 300,000 inhabitants (Maribor as the main city of this region, together with its more narrow environment, approx. 180,000 inhabitants). It was decided to gather the data in the main health care institution of the Podravska region, The University Clinical Centre Maribor (UKC). Every injured individual, where the potential exists, that he/she deliberately harmed him- or herself, gets sent to the UKC, usually first to the emergency unit (health care provided by the internist or surgery professionals), and later to the psychiatric unit. That is why in Slovenia a network was constructed between Maribor`s emergency, internist, chirurgic and psychiatric unit.

Data is being gathered by the patient`s doctor, therapist or nurse, i.e. someone who is in direct therapeutic contact with the patient in question.

The monitoring form has been translated. Data will be sent back in paper form and first data will be available in autumn.

The monitoring activity is performed on an actual basis, no calculation factor has been provided.

A data file with the monitoring activity on suicide attempts for the period June 2007 June 2008 will be sent in November 2008.

The primary source of information on suicide is the Institute of Public Health of the Republic of Slovenia, which is collecting raw data and suicide rates for Slovenia as a whole and the individual regions. These data are available to the general public and can be accessed online. Currently, the available data on suicide rates were splitted up according to gender for the years 1997-2006, as well as a more detailed differentiation on age (age groups: 0-9 yrs, 10-19 yrs, 20-29 yrs, 30-39 yrs, 40-49 yrs, 50-59 yrs, 60-69 yrs, 70-79 yrs, 80 yrs and above) and gender together, for the years 2000-2006. Files, sent to us, are in the form of e-data, usually Excel tables.

Suicide rates in Slovenia remain fairly stable and above-EU-average. The highest-ever suicide rate has been reported in 1984, when this number reached 35.8. Rates for men are higher than those for women. In the last 10 years, the peak was achieved in 1998, when 612 Slovenian citizens died of suicide. The suicide index (nr. of suicides per 100,000 people) reached 59.5 for males and 15.8 for females. Between the ages 25 and 45, suicide is the leading cause of death.

In the time-frame of 2001-2006, the age group of 50-54 years was the one with the most suicide deaths. Perhaps the most surprising is the untypically high suicide rate in the age group of 40-44 years, which encompasses adults in the most creative and dynamic period of life. This peculiarity of Slovenia would certainly be worth further investigative work.

In Slovenia, death from suicide is the leading cause of Future Income Lost; the first leading cause of Valued Years of Potential Life Lost (VYPLL); the second leading cause of Working Years of Potential Life Lost (WYPLL) with an average number of

21.7 years per person dying prematurely; the second leading cause of Premature Years of Potential Life Lost (PYPLL) with 29.7 years per person that died prematurely, and the third leading cause of premature death, 15.9 per 100,000 inhabitants, aged 0-64.

When it comes to suicide methods, hanging is by far the most common method in males as well as in females, followed by the use of firearms in men and drowning in women.

Additionally, data is available on different forms of self-harming behaviour, that get a confirmation of this diagnosis in the hospital, together with secondary diagnoses of these patients, in case they have any. Data are available for the whole year 2006 and are expecting data for 2007 and 2008. The gender ratio of attempted suicide is about 1:1, according to reported data of the previous years. The number of these acts, however, is probably highly underestimated, since the majority of self-harmers do not come into contact with the health system, and even if they do, it depends on their medical doctor, whether or not they get appropriately recognized as (non-)suicide attempters. There are two main problems, related to this issue: a. Suicide attempters who are not recognized as such, because of inadequate assessment, and b. Deliberate self-harmers, who get the designation of a `suicide attempt`, even though they did not have the intention to commit suicide via their self-harm. Thus, all of these issues need to be taken into consideration, when interpreting the results.

As is the case of raw data for suicide rates, data on causes of death is being noted and published online by the Institute of Public Health. It has been this way since 2000; in the time before, the Statistical Office of the Republic of Slovenia collected this data. The assessment of data is a highly developed and standardized way of data collection. On the basis of an equal methodology of data collection and assessment, the results are comparable to other European countries. Individual administrative units send the so-called `Death-Reports – DEM2 Sheets` to the Institute; attached are the sheets `Health Report on Death and Report on the Cause of Death`.

In the time period of 1979 – 1996, causes of death were classified according to the International Classification of Disease, Injury and Cause of Death – ICD, IX. Revision. After 1996, they have been classified according to the International Classification of Disease and Disease-Related Health Problems for Statistical Purposes – ICD, X: Revision, which was implemented from the part of the who in 1993. These two revisions are not directly comparable.

In Slovenia currently data are available on causes of death for the time-frame of 1997-2005. Again, data is available for Slovenia as a whole and for the particular regions. External causes of death are among the top five causes of death; in the mentioned time frame, they take the 3rd place position.

The **car accident statistics** are available online on the http://epp.eurostat.ec.europa.eu page. Currently, the statistics for years between 1995 and 2006 are available. In Slovenia, despite a relatively high rate of car accident mortality, the death rate dropped from 209/one million in 1995 to 131/one million in 2006, which means a reduction of more than 1/3. The car driving policy in Slovenia had become stricter and stricter since the authorities raised the stakes and severity of punishment for speeding, which is the No1 driving safety problem in Slovenia. however, these numbers are still a lot lower than suicide rates in Slovenia. Despite this fact, much more attention is placed on the discussion about how to reduce the number of traffic fatalities, than how to reduce suicide rates.

As far as **undefined causes of death** are concerned, some systematic research data available. One way of investigating undefined causes of death, is to compare the properties of suicides, fatal traffic accidents and remaining deaths (predominantly natural causes of death) with the properties of unexplained causes of death among which suicides may be concealed. If the undefined causes are closer to the charcteristics of natural deaths, there may be more natural deaths among the unexplained group of deaths. Similarly, if undefined causes in their main characteristics resemble suicides, there may be more suicides among them. In a Slovenian study, led by prof. A. Marusic in 2003, in comparison to undetermined deaths, significantly more men died in fatal traffic accidents as well as due to suicide. Persons in the groups of fatal traffic accidents and suicides were found to be

significantly younger than those dying from undetermined causes of death, while persons dying from remaining causes of death were found to be older. The marital status profile of undetermined causes of death seems similar to the group of suicides. Also, undetermined deaths and suicides are both more likely to occur in April and May. On the basis of similarities with the group of underdetermined deaths in the aspect of seasonality and marital status, an underestimation of actual number of suicides could be assumed. On the basis of certain differences between the two groups in gender and age, it could be concluded, that some cases of older female suicides are concealed within the undetermined deaths group.

One possible way of identifying `groups at risk` is on the basis of the patients` data, collected in the hospitals. The University Clinical Centre Maribor conducts an office on Medical Statistics, where data from individual units/departments gets sent to. Information about the most dangerous as well as most common methods can be obtained from here. On this data it is also tried to provide us a satisfactory insight into the so-called `hot-spots`. With `face to face`-assessment of patients, a qualitative interview might, of course, be the most informative way.

Systematic investigative work is another option. In Slovenia already a few studies have been completed, in which some `groups at risk` were investigated and identified:

People with disabilities, chronic physical illness as well as a history of severe pain or painful treatment procedures (the Slovenian study, which was one of the first investigations to tackle the problem of depression and suicidality in adulthood childhood cancer survivors, showed that in cancer survivors, significant depressive symptoms are three times more frequent than in their controls (Sveticic et al., 2005). The symptoms are often coupled with being female, having lower education, a single or divorced marital status, not attending association group meetings and reporting weaker sociability. The latter is also associated with weaker sociability. The latter is also associated with suicidal thoughts and plans. A recent Slovenian study of 420 people with non-insulin dependent diabetes mellitus (NIDDM) and insulin dependent diabetes mellitus (IDDM) (Kozel and Marušič 2006), showed that more than 40% had a prevalence for depressive symptoms, with 32.8% of those showing symptoms

admitting to active suicidal ideation, in marked contrast to the 8.5% with active suicidal ideation where serious depressive symptoms were absent. Depression is approx. twice as frequent in the population with a history of chronic childhood disease as in those with no such history. Primary health care workers, specialists and non-governmental organizations in touch with survivors need to be aware of the increased likelihood of depressive symptoms and the associated suicidal risk in this group. Furthermore, strategies aimed at de-stigmatization of the disease, patients' integration into society and working on their, often lowered self esteem and weakened sociability should also be considered.

It is proposed the following guidelines for the public health prevention in terms of reducing the risks of suicidal behaviour amongst patients with somatic diseases: a. Sensitivity to depressive signs and symptoms, b. improved recognition and appropriate treatment of depression, at primary care level, c. introduction of non-governmental organizations to increase mental ill-health and suicide awareness – Patients with chronic somatic illness usually participate in associations that provide information, education, assistance and other benefits. Thus, in this case, a monitoring of depressive symptoms and suicidality can be monitored.

As well as coming to terms with permanent physical disability, and all its consequences, **spinal cord injury patients** also need to face the additional burden placed on them by society. Our results on individuals with paraplegia, tetraplegia or amputation following a motor vehicle accident in Slovenia (Jurisic and Marusic in press) showed extremely high suicidality rates for all the groups, which correlated with low total self-esteem, presence of post-traumatic stress disorder symptoms and, interestingly but not surprisingly, a history of suicide in the family. Intrusive thoughts, feelings and images of the accident, correlated with suicidal thinking and planning of suicide. Patients with spinal cord injury need good psychosocial rehabilitation, especially paying attention to patients` self-image following their medical care, in particular when they return to their own social contexts.

An increased rate of suicide towards the end of adolescence indicate **youths** as another important vulnerability group where early detection should be of primary concern from a public health perspective. As far as age groups are concerned, the

elderly are a specific risk group as well. Slovenia is the No1 country worldwide, when it comes to suicides in the 65-and-older age group.When it comes to completed suicide, **male gender** is also a risk factor. **Single** or **divorced marital status** is another one. The No1 group at risk, however, remain the persons, **suffering from a mental illness**. In Slovenia, investigative results confirmed depression, alcohol dependency and schizophrenia as the crucial predictive factors. **Previous suicide attempt** remains the key risk factor for suicide.

As far as dangerous methods are concerned, **hanging** is the most lethal method in Slovenia, which is a peculiarity of our country. In Slovenia, the women: men ratio in case of individual suicide methods is as follows:

1. Drowning (5:4)
b. Poisoning with solid and liquid substances (4:5)
c. Jumping into depth (3:4)
d. Hanging (2:9) and
e. Firearm (close to 1:12).

The overall women: men suicide ratio is 2:7. As far as suicide rates of females are concerned, Slovenia has the third highest rate in the world.

For an effective risk evaluation, the time factor needs to be taken into consideration as well. Slovenia is an area with very distinctive seasons, and **springtime** is the season with the highest suicide rate. **Monday** is the weekday when most Slovenian suicides occur, but only after our country gained independence. Before that, in times of socialism, suicides on Monday were no more frequent as on other weekdays.

Success in early detection of harmful stress, mental ill-health, and suicidal behaviour is substantially dependent on systematic solutions at the macro level. Good policy-making is essential in order to select and implement cost-effective interventions that can optimize the use of usually modest or limited resources. Suicide prevention interventions and strategies can only be effective by the combination of knowledge and skills used in different disciplines at different stages of the suicidal process and on different vulnerability groups. Lessons from management and in particular from social marketing, both until now scarcely employed approaches in suicide prevention,

can provide a key contribution to the implementation and process optimization of individual interventions.

Unfortunately, Slovenia is still lacking a systematic suicide prevention plan - even more so, a comprehensive one. This certainly is hard to understand, since suicide represents the No.1 health concern in the country. To date, there are no systematic prevention plans in the individual regions, either, although some activities (e.g. education courses for GPs in order to improve the recognition of depressive disorders in practice), are aimed at increasing mental health awareness and reducing negative mental health - and, thus, reduce suicide risk. But the activities in this direction are mainly from the part of individual enthusiasts, since the priority of health-, social- and other politics seems to bypass the problem of suicide.

The rare suicide prevention interventions in Slovenia are implemented at a private association level, primarily by means of telephone help lines. In the last years, some websites on mental health have also been constructed, that provide information and social support, but so far, they are aimed at mental health problems in general, not suicide specifically.

The high rate of hanging places considerable limitations on the reduction of suicides through method restriction, as it is not possible to create a policy which would restrict access to this means, except in institutional settings. When it comes to the use of firearms and poisoning, however, a restricted access to these means has proven itself to be a successful method of prevention. The firearm policy in Slovenia is already quite restrictive, but persons whose profession involves the use of firearms (i.e. police), remain at higher risk than the general population.

The Slovenian Government has, however, just a couple of weeks ago, accepted a mental health legislation, which will, hopefully, be just the first step into a well-defined public mental health policy, a national suicide prevention plan included.

3.15 The associated beneficiary in SPAIN: Oviedo (University of Oviedo, Psychiatry)

The money was transferred to Oviedo in May 2008. Suicide Attempt data are available for the year 2003. Further reporting has not been recivied up to now from the Spanish centre (Prof. Bobes).

3.16 The associated beneficiary in SWEDEN: Stockholm (Karolinska Insitute)

Stockholm received the payment from EU in May 2008. Suicide attempt data were continuously sent to the coordination centre. In Würzburg data for the period from 1989 to 2005 are available for this centre and already have been analysed.

The Stockholm Centre NASP (National Prevention of Suicide and Mental Ill-Health at Karolinska Institut and Stockholm County Council's Centre for Suicide Research and Prevention of Mental Ill-Health) translated and adopted the common monitoring form to monitor attempted suicide in a catchment area of the Stockholm County Council.

The catchment area comprises two municipalities (Huddinge, Botkyrka) and three parishes (Hägersten, Bränkyrka, Skärholmen). The demographic units correspond to the catchment area of Huddinge University Hospital. Number of inhabitants of the catchment area is around 280,000 to 300,000.

All patients who seek help at Huddinge University Hospital after an attempted suicide are registered. Data on attempted suicide patients are gathered from emergency wards and from the patient's medical journals. In depth data, according to the monitoring form, are collected for six months every year, namely January, February, March, and July, August and September.

The data collection for the year 2007 has been completed, the last quality check was performed recently, and a data file will be sent to the Würzburg Co-ordinating Centre by the 25th of September 2008. The number of suicide attempts for the period of 1st of June-31st of December 2007 was 294. The screening is performed by a research

assistant who documents the events on EXCEL files. Before registration of the suicide attempt, the event is thoroughly checked e.g. regarding the belonging to the catchment area. From June 1st 2007 through December 2007, all events have been registered and documented on EXCEL files.

The medical journals for the events occurring during July 1st through Sept 2007, has been collected and the in depth data were recorded according to the registration form. The forms were coded and transformed to SPSS files. The number of events for the three-month period in 2007 was 176. The data collection for 2008 is still underway.

The calculation factor for the data of the Stockholm Centre is derived in the same way as in the WHO multi-centre study on parasuicide/ attempted suicide and the estimation factor has previously been 1.05 – 1.11. The factor will be revised for 2007.

The results of the previous monitoring show that a large majority of attempted suicide patients seek help at Huddinge University Hospital and only a very few go to district medical centres. It is estimated that at least 90-95 percent of patients who seek medical care after an attempted suicide, seek care from the hospital.

The reliability and validity has been tested on several occasions during the previous years and will also be tested for 2007 and 2008.

Prior to the studies initiation, comprehensive oral and written information was delivered to the wards which come into contact with patients who have attempted suicide. This information is continuously updated by research assistants. Researchers attend regular meetings with Professor Danuta Wasserman and Professor Birgitta Floderus (Professor of Epidemiology at NASP), during which monitoring procedures are discussed.

All original data are kept in locked record cabinets.

Suicide data are available by age, gender, and methods.

National data on suicides for 2006 has recently been available. For the data on suicide for the catchment area the Stockholm centre is waiting, to be obtained from the Swedish National Board of Health and Welfare. When these source data are delivered, a data base on suicide attempts at the national level and for the catchment area will also be obtained.

Our interpretation is that the causes of death shall correspond to ICD10: Y10-Y34. The data are available by gender and 5-year age groups. The data source is the Causes of Death Register at the Swedish National Board of Health and Welfare. Years available include 2006. No files have been sent to the coordination centre. The outcome is described below.

In Sweden, the Swedish National Programme for Suicide Prevention was approved by the parliament in June 2008. The National Suicide Preventive Plan works according to the following strategies:

1. Promote better life opportunities to support the groups that are most at need;
2. Minimize alcohol consumption in target groups and high risk groups;
3. Reduce the availability of methods and means to commit suicide;
4. Effective management of psychological disturbances;
5. Supporting medical, psychological and psychosocial services in preventing suicide;
6. Dissemination of knowledge and evidence based methods for reducing suicide;
7. Raising competence of key health care and prison staff who care for people with suicidal problems;
8. Analysis of suicide cases which occurred within the health care system and 28 days after discharge from the health care system. It is obligatory to report all cases to the Swedish National Board of Health and Welfare;
9. Supporting voluntary organisations.

NASP has performed reviews of all scientific articles before the respective strategy was written, which are published in NASP reports.

Concerning the 'hot spots', before any suicide preventive decisions can be taken, analysis of data for the Stockholm County Council catchment area for more than 1 year is necessary.

The most common method of attempted suicide is intoxication by medicines. The majority of the medicines used may be classified as sleeping pills, tranquilisers, neuroleptics, analgesics and muscle relaxants. Antidepressants were seldom used in this context.

The nine Suicide Preventive strategies are also applied in Stockholm County Council area, which have in addition, decided on a "Null-Vision" for Suicide.

The preventive interventions are performed at the National and County level. Organisations responsible for preventive interventions are NASP (who has an expert function as advisor to the Swedish Government and Stockholm County Council with regard to the prevention of suicide and mental ill-health) as well as the Swedish National Public Health Institute and the Swedish National Board of Health and Welfare. The government has also adopted the "Null-Vision" for suicides in Sweden.

The Stockholm centre is in connection with the Israel centre and is performing special analyses of suicide attempt rates of migrants. These analyses are performed before the background that previous analyses showed high rates of suicide attempts for persons with migration background, especially also persons with migration background from the second generation and females.

3.17 The associated beneficiary in TURKEY: Ankara (University Crisis Intervention Center)

Suicide attempt data from 1998 to 2000 are available in the data matrix of the coordination centre.

Dr. D. Özgüven took over the leadership from Prof. Sayil due to health problems. The permission of the institution is still missing, necessary information from the

coordination centre was sent to Ankara. A new bank account has to be arranged. The report is in progress.

The Ankara centre is also performing special analyses concerning persons with migration background, especially with Turkish migration background in various European countries.

4. Financial Report

The financial report includes the preliminary status and includes all centres, which have been sent their detailed financial report for the first reporting period in time.

Please see appendix 1.

Appendix 1: The revised WHO-monitoring form to assess suicide attempts

1	**Hospital:** …… ☐	**2**	**Department:** …… ☐
3	**Name, first name:** ……..…….. **ID-Nr.**	**4**	**Sex:** 01 – male 02 – female 03 – changed from male to female 04 – changed from female to male 09 – not known
5	**Date of birth:** (day/month/year) ……/……/…… **6** **Age** (years) ……..	**7**	**Date of suicide attempt:** ……...../……/…..... **8** **Time of suicide attempt:** ..... *(hours)*
9	**Country of birth:** …….... ☐☐☐	**10**	**Duration of living in the country of current residence:** ……*(years)*
11	**Country of destination:** *(arrived from which country)* …….…... ☐☐☐	**12**	**Citizenship:** *(name of the country)* …….. ☐☐☐
13	**Ethnicity:** ☐☐☐		
14	**Mother's country of birth:** *(name of the country)* …….... ☐☐☐	**15**	**Father's country of birth:** *(name of the country)* …….. ☐☐☐
16	**Brought up:** 01 – in traditional family 03 – by other relatives 05 – in institution 09 – not known 02 – by single parent 04 – in adoption or care family 06 – something else, specify……		
17	**Residence within the catchment area at the time of the suicide attempt:** *(national classification)* Postal code: ☐☐☐☐☐		
18	**Change of address during the last 12 months:** 01 – one year ago was the same 02 – change of address in same catchment area 03 – change of address, resided outside catchment area 04 – change of address, resided abroad 09 – not known	**19**	**Religious affiliation:** 01 – none (atheist) 02 – no religious affiliation (indifferent) 03 – protestant 08 – greek orthodox 04 – catholic 09 – Buddhist 05 – jewish 10 – other, specify ……..…..……..… 06 – muslim 99 – not known 07 – hindu
20	**Current civil state:** 01 – never married 03 – divorced 05 – first marriage 07 – legal cohabiting 02 – widowed 04 – separated 06 – second or subsequent marriage 09 – not known		
21	**Usual household composition during the last year:** 01 – living alone 02 – living alone with children 03 – living with partner without children 04 – living with partner and children 05 – living with parents 06 - living with other relatives/friends 07 – living in psychiatric institution 08 – living in jail 09 – living in institutions 10 – living in homes for elderly 11 – other, specify ……. 99 – not known	**22**	**Household composition at the time of the suicide attempt:** 01 – living alone 02 – living alone with children 03 – living with partner without children 04 – living with partner and children 05 – living with parents 06 – living with other relatives/friends 07 – living in psychiatric institution 08 – living in jail 09 – living in institutions 10 – living in homes for elderly 11 – other, specify……..…… 99 – not known
23	**Level of education:** *(highest completed education)* 01 – below compulsory level 03 – high school or vocational level 09 – not known ☐ 02 – compulsory level 04 – university/similar institution level		
24	**Current (or last) occupation:** ……..		
25	**Occupation:** 1000 – legislators, senior officials and managers 2000 – professionals 3000 – technicians and associate professionals 4000 – clerks 5000 – service workers and shop and market sales workers 6000 – skilled agricultural and fishery workers 7000 – craft and related trades workers 8000 – plant and machine operators 9000 – elementary occupations 0008 – not applicable 0009 – not known	**26**	**Level of economic position, employment status:** 01 – full time permanently employed (incl. self-empl.) 02 - part-time permanently employed (incl. self-empl.) 03 – employed, but on sick level 04 – full-time temporary work 05 – part-time temporary work 06 – unemployed 07 – full-time student or apprentice 08 – military service 09 – imprisoned 10 – disabled, permanently sick or early retired due to sickness 11 – retired 12 – housewife/homemaker 13 – not working 14 – other, specify ……..……

27 **Duration of being factually unemployed:**
…….. *(weeks)* 888 – not applicable 999 – not known

28 **Specification of the mean of suicide attempt:** *(the method(s) and circumstances of suicide attempt)*
……
……
……

29 **Method(s) of the suicide attempt:** *(according to the ICD-10, Chapter XX)* **ICD-10 code**
Method 1 ……
Method 2 ……
Method 3 ……
Method 4 ……

30 **Injury, poisoning and other consequences:** *(according to the ICD-10, Chapter XX)* **ICD-10 code**
……

31 **Medication prescribed:**
01 – no
02 – yes, for me
03 – yes, for somebody else
04 – not applicable
09 – not known

32 **Place of suicide attempt:**
01 – home
02 – medical institution
03 – other public place, specify
……
09 – not known

33 **Number of previous suicide attempts:**
00 – never
99 – not known
(number)

34 **Contact with health system after previous suicide attempt:**
00 – never
88 – not applicable
99 – not known *(number)*

35 **Contact with other services after previous suicide attempt:**
00 – never
88 – not applicable
99 – not known *(number)*

36 **Previous suicide attempts within 1 year:**
00 – never
99 – not known
(number)

37 **Contact with health system after previous suicide attempt within 1 year:**
00 – never
88 – not applicable
99 – not known *(number)*

38 **Contact with other services after previous suicide attempt within 1 year:**
00 – never
88 – not applicable
99 – not known *(number)*

39 **Contact with health system after the most recent suicide attempt:**
01 – no
02 – yes, with emergency doctor
03 – yes, general practitioner
04 – yes, non-psychiatric (somatic) inpatient
05 – yes, psychiatric inpatient
06 – yes, non-psychiatric (somatic) outpatient
07 – yes, psychiatric outpatient
08 – yes, psychotherapeutic inpatient
09 – yes, psychotherapeutic outpatient
10 – yes, professional counselling services
11 – yes, voluntary services (e.g. telephone hotline, other voluntary service)
12 – yes, addiction treatment
13 – other, specify ……
88 – not applicable
99 – not known

40 **Recommended next care:**
01 – no
02 – yes, with emergency doctor
03 – yes, general practitioner
04 – yes, non-psychiatric (somatic) inpatient
05 – yes, psychiatric inpatient
06 – yes, non-psychiatric (somatic) outpatient
07 – yes, psychiatric outpatient
08 – yes, psychotherapeutic inpatient
09 – yes, psychotherapeutic outpatient
10 – yes, professional counselling services
11 – yes, voluntary services (e.g. telephone hotline, other voluntary service)
12 – yes, addiction treatment
13 – other, specify ……
88 – not applicable
99 – not known

41 **Psychiatric diagnosis:** *(according to ICD-10, Chapter V)* **ICD-10 code**
First psychiatric diagnosis ……
Second psychiatric diagnosis ……
Third psychiatric diagnosis ……

42 **Classification of suicide attempt:**
01 – deliberate self-harm (non-habitual)
02 – parasuicide pause/temporary test
03 – parasuicide gesture
04 – serious suicide attempt
09 – not known

43 **Certainty of rating of classification:**
01 – certain
02 – uncertain
09 – not known

44 **Accidental overdose:**
01 – yes
02 – no
09 – not known

45 **Reasons of suicide attempt:** *(direct risk factors)*
01 – interpersonal conflict (with family member, partner, friend)
02 – bereavement or severe illness of family member, partner, friend
03 – physical illness
04 – mental health disturbance
05 – financial difficulties
06 – mistreatment
07 – legal problems
09 – not known
08 – other, specify ……

Contacts of the interviewer:
Name: ……**Phone:** ……

Appendix 2: Detailed financial report for the first reporting period (2007-06-01 – 2008-06-01)